MoDOT/MSHP Medical Plan Summary of Benefits Comparison
Effective January 1, 2004

Listed below is a partial outline of health services covered under the MoDOT/MSHP Member Handbook or Coventry's Certificate of Coverage. This summary should not be relied upon to fully determine coverage. See the MoDOT/MSHP Member Handbook or Coventry's Certificate of Coverage for applicable limits and exclusions to coverage for these health services. If differences exist between this summary of benefits and the handbook or certificate, the handbook and certificate govern.

	PLAN 1		PLAN 2			PLAN 3
Benefit	**HEALTHLINK PPO PLAN** Available Statewide		**HEALTHLINK OPEN ACCESS III PLAN **** Not Available Statewide See Service Area Map			**COVENTRY** Available in Western Area Only See Service Area Map
	HealthLink PPO and Freedom Network	**Out of Network Provider ***	**HealthLink HMO**	**HealthLink PPO**	**Out of Network Provider ***	
	Member's Responsibility					
Deductible						
Individual	$ 300	$ 300	$ 0	$ 300	$ 500	$ 0
Subscriber +1	$ 600	$ 600	$ 0	$ 600	$ 1,000	$ 0
Family	$ 900 maximum	$ 900 maximum	$ 0	$ 900 maximum	$ 1,500 maximum	$ 0
Coinsurance	10%	20%	NA	20%	30%	NA
Out-of-Pocket Maximum						
Individual	$750	$1,500	$1,000	$1,500	$2,000	$1,000
Subscriber +1	$1,500	$3,000	$2,000	$3,000	$4,000	$2,000
Family	$2,000	$4,500	$2,000	$3,000	$6,000	$3,000
Lifetime Maximum	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000	Unlimited
Office Visit	$15 copayment for office visit only. Other services applied to deductible and coinsurance.	20% coinsurance of allowed amount after deductible	$15 copayment	$15 copayment for office visit only. Other services applied to deductible and coinsurance.	30% coinsurance of allowed amount after deductible	$10 copayment
Immunizations	$0 copayment or 0% coinsurance of eligible expenses from birth through age five.	20% coinsurance of allowed amount after deductible	$0 copayment or 0% coinsurance of eligible expenses from birth through age five.	$0 copayment or 0% coinsurance of eligible expenses from birth through age five.	30% coinsurance of allowed amount after deductible	$0 copayment from birth to 72 months of age.
Preventive Care	Member responsible for amount in excess of $100 per calendar year. (Benefit applies to active employees and enrolled spouse only)	Member responsible for amount in excess of $100 per calendar year. (Benefit applies to active employees and enrolled spouse only)	Member responsible for amount in excess of $350 per calendar year. (Benefit applies to subscriber and enrolled dependants)	Member responsible for amount in excess of $350 per calendar year. (Benefit applies to subscriber and enrolled dependants)	Available in network only	$10 copayment
Inpatient Hospital Care	10% coinsurance after deductible Pre-admission Certification Required	20% coinsurance of allowed amount after deductible. Pre-admission Certification Required	0% of eligible expenses. Pre-admission Certification Required.	20% coinsurance after deductible. Pre-admission Certification Required.	30% coinsurance of allowed amount after deductible. Pre-admission Certification Required.	$0 copayment
Urgent Care	$15 copayment for office visit only. Other services applied to deductible and coinsurance	20% coinsurance of allowed amount after deductible	$35 copayment	$35 copayment for office visit only. Other services applied to deductible and coinsurance.	30% coinsurance of allowed amount after deductible. Other services applied to deductible and coinsurance.	$10 copayment
Surgery	10% coinsurance after deductible. Pre-admission Certification Required	20% coinsurance of allowed amount after deductible. Pre-admission Certification Required	0% of eligible expenses. Pre-admission Certification Required.	20% coinsurance after deductible. Pre-admission Certification Required.	30% coinsurance of allowed amount after deductible. Pre-admission Certification Required.	$0 copayment

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	Member's Responsibility					
Allergy Injections	10% coinsurance after deductible.	20% coinsurance of allowed amount after deductible.	$15 copayment with office visit; $5 per injection without office visit	20% coinsurance after deductible	30% coinsurance of allowed amount after deductible.	$10 copayment
Emergency Room Services	$75 copayment and 10% coinsurance after deductible. Copayment waived if admitted or accidental injury.	$75 copayment and 20% coinsurance of allowed amount after deductible. Copayment waived if admitted or accidental injury.	$75 copayment Copayment waived if admitted or accidental injury.	$75 copayment and 20% coinsurance after deductible. Copayment waived if admitted or accidental injury	$75 copayment and 30% coinsurance of allowed amount after deductible. Copayment waived if admitted or accidental injury	$75 copayment Waived if admitted or authorized by First Help.
Maternity	10% coinsurance after deductible.	20% coinsurance of allowed amount after deductible.	$15 copayment for initial visit. All other prenatal visits, delivery costs, and routine post-natal visits covered at 100%	20% coinsurance after deductible.	30% of coinsurance of allowed amount after deductible.	$10 copayment per member per provider per date of service.
Chiropractic Services	10% coinsurance after deductible; Benefit limited to 30 manual manipulation of the spine treatments per calendar year and 1 X-Ray by a chiropractor per calendar year. Office visit not covered.	20% coinsurance of allowed amount after deductible; Benefit limited to 30 manual manipulation of the spine treatments per calendar year and 1 X-Ray by a chiropractor per calendar year. Office visit not covered.	$10 copayment; Benefit limited to 30 manual manipulation of the spine treatments per calendar year and 1 X-Ray by a chiropractor per calendar year. Office visit not covered.	20% coinsurance after deductible; Benefit limited to 30 manual manipulation of the spine treatments per calendar year and 1 X-Ray by a chiropractor per calendar year. Office visit not covered.	30% coinsurance of allowed amount after deductible; Benefit limited to 30 manual manipulation of the spine treatments per calendar year and 1 X-Ray by a chiropractor per calendar year. Office visit not covered.	$10 copayment per visit up to 32 visits from original onset and prior authorization required.
Mental Health (MH)/Chemical Dependency (CD) - Inpatient	10% coinsurance after deductible; 30 day annual maximum and lifetime maximum of 4 times annual for chemical dependency only.	20% coinsurance of allowed amount after deductible; 30 day annual maximum and lifetime maximum of 4 times annual for chemical dependency only.	Available at PPO and out of network level of benefits only.	20% coinsurance after deductible; 30 day annual maximum and lifetime maximum of 4 times annual for chemical dependency only.	30% coinsurance of allowed amount after deductible; 30 day annual maximum and lifetime maximum of 4 times annual for chemical dependency only.	**Mental Health** - $0 copayment; 90 days maximum per calendar year. **Chemical Dependency** - $0 copayment; 30 days maximum per calendar year.
Mental Health (MH)/Chemical Dependency (CD) - Outpatient	Outpatient office visit: $15 copayment; outpatient hospital: 10% coinsurance after deductible; 20 day annual maximum and lifetime maximum of 4 times annual for chemical dependency only.	20% coinsurance of allowed amount after deductible; 20 day annual maximum and lifetime maximum of 4 times annual for chemical dependency only.	Available at PPO and out of network level of benefits only.	Outpatient office visit: $15 copayment; outpatient hospital: 20% coinsurance after deductible; 20 day annual maximum and lifetime maximum of 4 times annual for chemical dependency only.	30% coinsurance of allowed amount after deductible; 20 day annual maximum and lifetime maximum of 4 times annual for chemical dependency only.	**Mental Health** - covered in full for the first 2 visits and then subject to 50% coinsurance for all visits thereafter with a Mental Health Professional designated by Coventry. **Chemical Dependency** - covered in full for the first 2 visits and then visits 3 - 26 are covered at a 50% coinsurance.
Organ Transplant Coverage (Not Through HealthLink)						

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	Member's Responsibility					
Organ Transplants (Network affiliation is determined through the Organ Transplant Carrier)	100% coverage for transplant and 18 months following the transplant within transplant carrier's network.	20% of network cost to the closest in-network facility within transplant carrier's network plus the difference between the network and actual cost.	100% coverage for transplant and 18 months following the transplant within transplant carrier's network.	100% coverage for transplant and 18 months following the transplant within transplant carrier's network.	20% of network cost to the closest in-network facility within transplant carrier's network plus the difference between the network and actual cost.	Covered as other medical conditions.
Pharmacy Benefit - Available Through Eckerd Participating Pharmacies Only						
Deductible	$75		$0			$0
Generic	30% coinsurance after deductible per calendar year at retail and mail order pharmacy with $5 minimum copayment.		20% coinsurance at retail and mail order pharmacy with $5 minimum copayment.			**Generic Formulary** - $5 copayment for 31 -day supply and $10 copayment for 93-day supply. **Brand Formulary** - $15 copayment for 31-day supply and $30 copayment for 93-day supply. **Non-Formulary** - $45 copayment for 31-day supply and $90 copayment for 93-day supply.
Brand	**If a generic is available:** 30% coinsurance of brand drug's cost plus the difference between the brand and generic after deductible per calendar year at retail and mail order pharmacy with $5 minimum copayment. **If no generic is available:** 30% coinsurance after deductible per calendar year at retail and mail order pharmacy with $5 minimum copayment. **If brand is medically necessary and approved by Eckerd:** 30% coinsurance after deductible per calendar year at retail and mail order pharmacy with $5 minimum copayment.		**If a generic is available: 2**0% coinsurance of brand drug's cost plus the difference between the brand and generic at retail and mail order pharmacy with $5 minimum copayment. **If no generic is available:** 20% coinsurance at retail and mail order pharmacy with $5 minimum copayment. **If brand is medically necessary and approved by Eckerd:** 20% coinsurance at retail and mail order pharmacy with $5 minimum copayment.			
Active Employee Out-of- Pocket Premiums						
Subscriber Only	$0.00		$48.00			$28.30
Subscriber/Family	$151.00		$297.00			$242.80
Subscriber/Spouse	$131.00		$227.00			$159.40
Subscriber/Child	$70.00		$166.00			$98.40
Subscriber/2 Children	$140.00		$248.00			NA

*** Out of Network Provider service insurance payments are subject to Usual and Customary Rates (UCR) only. The Member will be responsible 100% for amounts above UCR.**

**** HealthLink must be notified prior to any outpatient surgery, diagnostic and ancillary services and also prior to any elective hospital admission. Please have admitting physician or member call HealthLink, Inc. toll-free at (877) 284-0102.**